## PRINTED: 11/21/2008. FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDENGUPPLIENCUA IDENTIFICATION NUMBER: (XX) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A BUILDING B. WING 11/14/2008 00/2218 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1419 VAN BUREN STREET, NW WHOLISTIC SERVICES, X WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION SUMMARY STATEMENT OF DEPICIONCIES ID OU) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) REFIX DEFICIENCY W DOD W 000 INITIAL COMMENTS On October 27, 2008 at 3:36 PM, the State Agency (SA) received an unusual incident report Deceived 12/4 (LRR) via facsimile regarding Client #1. According 1.1 GOVERNMENT OF THE DISTRICT OF COLUMBIA to the UIR, on October 23, 2008 at 5:50 PM, the 31 direct staff noticed that Client #1's right leg was DEPARTMENT OF HEALTH. swollen from her knee to her ankle. The direct HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR care staff reported the findings to the house manager (HM). The HM informed the Registered - WASHINGTON, D.C. 20002 Nurse (RN) on the same day. The RN instructed tion in a fire the House manager, who was a Trained A SINE Medication Employee (TME) to administer PRN ANGETH TO THE (as needed) medication for pain. The Primary Care Physician (PCP) evaluated the client on the 23, 4 (1.144 - 1.42 following day ,October 24, 2008. The PCP . . ordered an x-ray of the client's right leg, which revealed that the client sustained a right distal fibular fracture. Due to the nature of the incident an on site investigation was initiated on October 29, 2008 to evaluate the facility's system's for ensuring health and safety to its clients. The findings of the investigation was based on observation at the group home and the day program; interviews with group home staff, day program staff, the Qualified Mental Retardation Professional (QMRP), the Registered Nurse and the HM; and the review of medical/clinical/administrative records. 483.410(c)(4) CLIENT RECORDS W 114 W 114 Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility OOD DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

Any deliciency statement ending with an asteriet (") denotes a deliciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-65) Previous Versions Obsolete

Event ID: E0FJ11

Facility ID: 09G218

If continuation sheet Page 1 of 11

## DEPARTMENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SEDVICES

PRINTED: 11/21/2008 FORM APPROVED: OMB NO. 0938-0391

If continuation sheet Page 2 of 11

		(X1) PROVIDER/SUPPLIENCUA	7770 M	14 71	LE CONSTRUCTION	(XS) DATE S	RVEY
	OF DEFICIENCIES FCORRECTION	IDENTIFICATION NUMBER:	A BUI		· <del></del>	COMPLE	
<b>'</b>			1				c 7
1		09G218	B. WAR	(G		11/	4/2006
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		······································
	ne oedlaced v				419 VAN BUREN STREET, NW	•	
WITCHES	nc services, x	·		¥	/ASHINGTON, DC 20012		i
(764) ID		TEMENT OF DEFICIENCIES	_D		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO		(745) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREF		GROSS-REFERENCED TO THE APPL DEFICIENCY)		DATE
W 114	Continued From pa	ige 1	W	114	787 4 4 A	7	
		Primary Care Physician			W 114		
		ries made in Client #1's			The physician has re-	1	
	medical record.				a copy of this stateme	ent of	
	The finding include	<b>s</b> :		1	deficiencies. The	1	را
	ļ				administration has h	1	1 12.
'		08 the direct staff noticed that			verbal discussions wi	th the	
		g was swollen from her knee to			physician on this sub	iect.	,
<u>.</u>	findings to the bour	ect care steff reported the se manager. The house		į	It is going to be a ma	• .	" -
	manager informed	the Registered Nurse (RN) on			on all Direct Care Sta		
1	the same day. The	RN instructed the House			(DCS), Qualified Mer		}
	manager, who was	a Trained Medication			Retardation Profession		<u>}</u> .
•	Employee (TME) to	administer pain medication to			(QMRPs), the	MAIN	1
	THE CHEIT. I HE PAR	mary Care Physician (PCP) t on October 24, 2008.			i		
	Interview with the F	Registered Nurse on October			administration, and a		1
	28, 2008, at 11:30 .	AM revealed that the physician			to ensure that the phy	/sician	
j	evaluated the clien	t on October 24, 2008. Řeview i			date and signs all	1	
} ;	of the client's recor	d on the same day revealed a	•		documents reviewed		
(	consultation form A	which which documented the nd treatment plan. Although		•	leaving the physician	's	, .
<b>!</b>	the Dhysician signe	d the form, the physician failed			office.		
ŀ	to date the form.				12	/01/08	
W 153	483.420(d)(2) STA	FF TREATMENT OF	W	153			\
	CLIENTS	İ					
	The facility must a-	Marian that all allegations	•				
	Mistresiment nect	nsure that all allegations of ect or abuse, as well as		Į			1
!!!	injuries of unknown	Source, are reported		l			
<b>j</b> [	immediately to the	administrator or to other			_		}
1	Officials in accordan	nce with State law through				•	
	established proced	ures,					
<b>!</b> !		j		.			
	This STANDARD	s not met as evidenced by:		- 1			
	Based on interview	and record review, the facility		-			
	Taked to ensure that	tali unusumi incidente					
	incinguið stjuries of	unknown origin were reported			•		
FORM CMS-25	87(02-09) Previous Versions	Obsolete Event ID; EOFJ11			The E1- 000910		· ·

Facility ID: 09G218

CENTE	RS FOR MEDICAR TOF DEFICIENCIES	H AND HUMAN SERVICES E & MEDICAID SERVICES		OM	INTED: 11/21/200 FORM APPROVEI IB NO. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUTLDING	LE CONSTRUCTION (XG)	DATE SURVEY COMPLETED
···		09G218	B. WING		C
NAME OF F	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	11/14/2008
WHOUS	TIC SERVICES, X		14	19 VAN BUREN STREET, NW ASHINGTON, DC 20012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAGH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION DATE
W 153			W 153		
W 156	officials according to Regulations (22 DC 3519.10) one of on (Client #1)  The finding include Review of an unusual Cootber 23, 2006, of that Client #1 was a swelling to the right anide. The origin of the incident report was x-rayed on Oct the client had a right Further review of the Notification section show evidence that reported immediate governmental agent the incident report in date of notification to after the swelling was 483.420(d)(4) STAF CLIENTS	ual incident report dated on October 29, 2008 revealed discovered to have sustained leg from the knee to the fithe swelling was unknown. reflected that the client's leg ober 24, 2008 and revealed hit distal fibular fracture. e Verbal Notification/Written of the incident report failed to this incident had been by to the administrator or cless as required. Additionally effects an October 27, 2008 of the State Apency (four days)	W 156	W 153 Staff have been trained on policies and procedures of incident reporting. The emphasis of the training was timely (within 24 hours) verbal/written notification of all agencies regarding an incident. In the future, the QMRP will work collaboratively with the incident management coordinator on this subject to ensure compliance.  12/01/08	1
1	or to other officials in within five working d	or designated representative in accordance with State law ays of the incident.		The investigation report was submitted to Wholistic Services' administration on 10/30/08 which is within	
fi ti	ailed to report the re the administrator or of oother officials in ac within five working da		hi	five working days of the date of the incident report.  12/01/08  IN THE FUTURE, PROVIDE SUBMITTED 5 DAY	15
M CM8-2667	(02-46) Pravious Versions O	begings Event ID: EOFJ11		TROM INCIDENT. 12/1/08	

ND PLAN C	r of Deficiencies of Correction	(XT) PROVIDENSUPPLIENCLIA IDENTIFICATION HUMBER:	A. BUIL	ULTIPLE CONSTRUCTION DING	(AS) DATE SURVEY COMPLETED	
		05G218	B. WIN	3	44#	C   <b>4/2008</b>
	ROYDER OR SUPPLIER TIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CO 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		141.2446
(XI) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST ME PRECEDED BY FULL 9C IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF COR	ELICHII IS DE	CONLITEUR (CE)
W 156	Continued From pa	ge 3	W 1	58		
į	The finding includes	<b>;</b>				
:	. retardation Professi	8, the Qualified Mental nai (QMRP) was asked if the		W 192 In the future, the fa	rilito's	,
	incident was being a The QMRP indicate	nvestigated by the provider.		Registered Nurse (R shall ensure that sta	IN)	3
W 192	investigation had no	t been completed. F TRAINING PROGRAM	W 18	training is done with	nin 24	
	For employees who	work with clients, training and competencies directed		implementation of a protocol. The House	1	
	toward clients' healt	h needs.		Manager, QMRP, at RN shall on a daily	nd the	. 4
	Based on observation review, the facility is	not met as evidenced by: on, interview and record filed to ensure employees		monitor staff to ensu compliance.	orsis ire	
ľ	neamcare needs, fo			In the case of an acqueed medical condition,	te	
1	The finding includes Cross referee to W3			the facility shall hold conference with the	a case	<u>:</u>
	<b>observed at the facil</b> October 30, 2008 no	ity on October 29, 2008 and		program's Interdisciplinary Te		:
- ∤;	willen in the hursing day program staff re	Protocol. Additionally, the	•	(IDT) to discuss the plan of treatment pri	lient's	. '
13	cuts. Review of the revealed that the nur	hile there on October 29, training documentation Ses provided training to staff		returning to his/her o	lay	
W 322 A	six day after the swe 483.460(a)(3) PHYS	CIAN SERVICES	W 32		/01/08	•
S	The facility must prov jeneral medical care	ride or obtain preventive and				

TATEMENT OF DEFICIENCIES (AT) PROMOBERSUI IND PLAN OF CORRECTION IDENTIFICATION		& MEDICAID SERVICES  (XT) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER:	1	WULTIPLE CONSTRUCTION	(NS) DATE	), 0938-039 SURVEY LETED
•			B. Wil		_	C
NAME OF F	PROVIDER OR SUPPLIER	08G218			1 11	14/2008
	TIC SERVICES, X			STREET ADDRESS, CITY, STATE, 21 1419 VAN BUREN STREET, NO	0000	
(X4) ID PREFD( TAG		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI		RON SHOULD BE THE APPROPRIATE	COMPLETION DATE
W 322	Continued From pa	ge 4	Wa		21)	<del> </del>
-	failed to ensure cen	s not met as evidenced by: and record review, the facility eral and preventative care the one client in the ti#1)				
	The findings include The facility failed to of the leg at the grou	ensure basic care for swelling up home and day program.				
	revealed that Client: X-rays revealed that	egistered Nurse (RN) on approximately 10:30 AM #1's right leg was swollen and she had austained a right		W 322 Cross Reference	W192.	****
,	(Rest, los, Compress nurse instructed the : while sitting and in be same day at approximation	The nurse instructed the iplement the "RICE Principle" sion and Elevation). The staff to elevate Client #1's leg ed. Observations on the nately 3:30 PM failed to if elevated the client's leg			12441700	
a h d	lay program staff reviewer of the clients frours after the client :	it returned to the day 19, 2008. Interview with the sailed that they were not acture until 1:45 PM, four arrived. According to the client was allowed to walk				
w in ci	ncouraged to elevate as no evidence that: as no evidence that: astructions to the day ients activities and or are by elevating her a	n and track and was not the lag while there. There the facility gave timely program to restrict the rovide preventative				
' 331   48	3.460(c) NURSING	CEDI ross		i	]	1

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/21/2008 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES				OMB N	<u>vo. 0</u>	938-03 <u>9</u>
	T OF DISTIBLENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPLE CONST LDING	RUCTION	(X3) DAT	PLEYE	
		09 <b>G</b> 218	B. WI	ıc			C 1/14/2	20 <b>6</b> 8
	PROVIDER OR SUPPLIER TIC SERVICES, X	-	·	STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012				
(XA) ID PREFIX TAG	i (EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X (EA	PROMIDER'S PLAN OF CO CH CORRECTIVE ACTIO S-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	6	(AG) CMPLETION DATE
W 331	The facility must preservices in accordance of the incide october 23, 2008, Manager was informated october 23, 2008, Manager was	ovide clients with nursing more with their needs.  Is not met as evidenced by: Is, and record varification, the revices failed to establish health care monitoring and accordance with clients' needs to the investigation. (Client for the investigation. (Client for the Primary Care Physician on October 29, 2008 and intreport revealed that on at 6:50 PM, the house med by the direct care staff that gwas swollen. The bed as "from the knee down to use manager, reported the common to be a trained medication administer PRN (as needed) in October 29, 2008 at 0 AM, the nurse was asked was not notified on October 23, e RN Indicated that the	W	W 3 The QM with defi Em wer (wir pri an trea	331.1  administration  RP held discus  the RN on the  iciency statement  phases of the many care  thin 24 hours) of  mary care physincident, and the  atment intervent  administration  d monthly meet  the nurses, and Q	and the sions of the sician of mely ation.  In will tings OMRPs to		
•	employee (TME), to pain medication. O approximately 11:0 why the physician v 2008? Originally the physician's office w notified, however, v was available 24 ho physician was avail stated that she dec	administer PRN (as needed) in October 29, 2008 at 0 AM, the nurse was asked was not notified on October 23.	-	The	e administration d monthly meet	n will tings MRPs to		

## PRINTED: 11/21/2068 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2020 MULTIPLE CONSTRUCTION (XX) DATE SURVEY COMPLETED A. BUILDING B. WING 09G218 11/14/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WHOLISTIC SERVICES, X WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (XIS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE HEFTX TAG EGULATORY OR LISC IDENTIFYING INFORMATION) DEFICIENCY W 331 Continued From page 6 W 331 x-rays obtained on October 24, 2008 revealed the cilent sustained a right distal fibular fracture. In addition, the RN did not evaluate the clients led until 9:00 AM on October 24, 2008. Review of the the facility's policy on Communication of Medically Related Issues, November 6, 2008 at approximately 1:40 PM revealed that new medical issues should be communicated to the physician. Although the policy indicated that the nurse would "prioritize" verbal notification to the physician, the person who originally notified the RN was not a nurse and therefor could not fully attest to the extent of the swelling, i.e. were W 331.2 pulses present, or if pitting edema was present. It is the practice of Wholistic Services that in a Interview with the PCP on November 14, 2008 at approximately 4:45 PM, revealed that he would situation where a client is have preferred to know about the client's swollen absent from his/her day leg when it was discovered. program due to medical reasons, a clearance be 2. The facility's RN failed to obtain clearance from the PCP to send Client #1 to her day program. obtained from the client's primary care physician Observation at the group home on October 29. prior to his/her return to 2008 at 9:30 AM revealed that the client was not the day program. present. Interview with RN on the same day at approximately 11:50 AM revealed that the client was at her day program. When asked if the The facility has reviewed physician had cleared the client to go to her day

program she indicated that he had not given an

order and that she authorized the staff to take the client to her day program. Review of the medical

record on the same day revealed that on October

physician's office for evaluation of the swelling to her right leg. The physician requested that an

x-ray be performed on the client's leg. The x-ray was performed on the same day and revealed

24, 2008, Client #1 was transported to her

such protocol with the RN

and House Manager. The

OMRP will work with the

RN and House Manager to

ensure compliance.

12/01/08

ND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLEMICUA IDENTIFICATION NUMBER	(XCZ) II A. BU		IPLE CONSTRUCTION	OMB NO. 0938-( OG) DATE SURVEY COMPLETED		
		09/3218	B. W		***************************************			
AME OF P	ROVIDER OR SUPPLIER	l		_		11/	14/2008	
WHOLIS'	TIC SERVICES, X	•		į P	GET ADDRESS, CITY, STATE, ZIP CODE 419 VAN BURGN STREET, NW			
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	<del></del> -i		VASHINGTON, DC 20012			
TAG		Y MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION SHOWN CROSS-REFERENCED TO THE APPROPRIES OF THE APPROP		COMPLETIC COMPLETIC	
W 331	Continued From p	age 7	1000	-	OLD (CENCY)			
-	that Client #1 had	S right dietal fibrica fra	W3	37			ı	
	THE NEW YORK OF THE	Yamondod flore the ethers to					]	
f		MORATIC CHIMAGE (ACC. T.					j	
1	i ara ilirine <b>ssenti iliri</b> k k	the client was scheduled to see 1940n on November 11, 2008.						
	TALL SEVEN IN LANGE	TATION CONTRACTOR AND ADDRESS OF THE STATE O						
- 4 '	AIGHT 862 DELIKE 184	177 St. 1744 (1684 (1984) 1884 1884 1884 1884 1884 1884 1884						
	Acimi recell the tube (	IN THE PERSON OF THE PERSON AS A PERSON OF THE PERSON OF T						
		e and had not given orders to the day program, or to restrict						
1	her activities.	e vay program, or to restrict						
1.		}			<b>'</b> %		• '-	
	nterview with the P	CP on November 14, 2008 at		-	·			
] •	サンマン はんしょう	Par Historian Hartan		- [		1		
į	hen be re-eavluste	lient see the specialist and d by him prior to the client					**	
17	eturning to the day	Program:		İ	•		_ 3	
	. The facility's num re day program sta acture.	Bing staff failed to ensure that iff was aware of Client #1's						
W	finen asked what ty Sticinated in white	aff was interviewed on approximately 2:45 PM, pes of activities the client at the program, he indicated	•					
, –, -			•					
					W 331.3	· <b>-</b> -		
444.	THE PER LINE WAS AND THE	n asked if he was aware that the to her right leg he			Cross Reference W192.			
1		PAR resumme			W192.			
	DIOXINAMENT 1:30 D	Market de de la la la la la la la la la la la la la			12/01/0	_		
					12/01/0	8	<b>.</b>	
pro	Com until cleaned	but he about the day				Ī		
							:	
						1		
001	KINDOR, Nº Indicated	that there was no call from		[				

TATEMEN	IT OF DEFICIENCIES	E & MEDICAID SERVICES  (X1) PROVIDERSUPPLENCIA			FOR	D: 11/21/20 M APPROV
VNID PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION	(XS) DATE	0,0938-03
		ł	A BUIL		COMP	LETED
VAME OF	PROVIDER OR SUFFLIER	09G218	B. WING		, c	
			I.	THE ADDRESS OF	11/	14/2008
MHOTI	TIC SERVICES, X		- 1	1419 VAN BUREN STREET, NW		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCES		WASHINGTON, DC 20012		
PREFIX TAG	(FACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO OROSS REFERENCE		(26)
lar pos			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	COPINATE OUT BE	DATE
W 331	Continued From pa	ge 6	W 33			
	the facility.		44 33	"[		
- 1	The driver who tran	manufacility of the con-	1			-
- [		sported the client to the day M delivered two envelopes	{			]
	A INT. MICH. C. BUKUNESAN	T TO ING SAME TILE				
	ANTI CONDUINGUICE AND	R S/l/freesead in the		1		
i	THE UCT OF CHARTS					•
pr pr	P: YS: \$111.   1/161   MJF	the client arrived to the day however, arrived at the day				
					İ	
	THE PROPERTY AND IN	17 17) British British and Albert Co	•		İ	•
		Transfer and the second				4 14
[6	Client #1. the day on	ministered medication to ogram staff indicated "no,"				
4		1		W 331.4		
1	nterview with the fac	lity's Registered Nurse on		77 331,4		
			ļ	The client's care plan ha	18	. !•
		The that the day program did If available on the premises,	-	veca updated. In the	1 1	
		1	•	future, such plan shall b	e	
4	. The facility's nursi	ng staff failed to update the	j	opulated within 24 hours	of	
	lients care plan to re lients condition.	flect the change in the	-	the occurrence of an		
١٩	rena condition,		)	incident.		
R	eview of the Health	Management Care Plan on		The QMRP shall review	1 1	
				We undated nion with it.	.	
111	HI BUCK OF CEAR	4 4447	1	TO CHEET that ALana		
		reladged that the document scord had not been	1	m the chent's health is	'	
ug	dated.	acord risid not been	1	addressed.		
	TL - 4 - 101 -	ŧ		12/01/0		•
ca	The facility's nurse re/treatment orders	failed to obtain		22,047	<u>منا</u>	
			1		,	- 1
100	Biview with the facili	ly's nurse on October 29,	•			
pla	Do the "RICE Dring	eased that she had put in	}		!	,
Co	Moression and Elect	ple (rest, ice,		· ·	1	1
		ponent of the protocol	1			
48-2967(DZ	99) Previous Versions Obs	Fiete Event ID: EOF/11				i
		EVENT ID: FIDE 194	<b>.</b>	1D; 09G218	(	I

AND PLA	ENT OF DEFICIENCIES WI OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:	(OCZ) MIL	ALTIPLE CONSTRUCTION	FOR	ED: 11/21/2 RM APPROVI IO. 0938-0
		(SALINA MUNDEK	A BUIL	DING	(OG) DATE	SURVEY
MALLE C	F PROVIDER OR SUPPLIER	09Q218	B. WING	G	_	C
			——————————————————————————————————————		11,	/14/2008
as LIOF	ISTIC SERVICES, X		1	STREET ADDRESS, CITY, STATE, 2 1419 VAN BUREN STREET, N		
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20012	**	
TAG	REGULATORY OR L	VIGINENT OF DEFICIENCIES VINUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	PREFEX TAG	PROVIDER'S PLAN DI (EACH CORRECTIVE AC GROSS-REPERSMORT)	IN SHOULD BE	CONFLETIO
W 331	LANGOG FIORD DB	ge 9	- <del> </del>	0 10-234	CY)	DATE
	Peduines that an av-	Atomic A	W 33			<del> </del>
	right leg. When as	ted if the Physician ordered		W 331.5		1
			i	The RN has been	advised	
	DEWENEL LEADER OF H	el to use the ace wish	}	to ensure that yes	bai	1
	same day failed to n	effect an order.		instructions are r	eflected	
	1			on the Physician'	order	
		ing staff to ensure timely care staff regarding Client	}	Sheets (POSs), an	d to	
	#1's fratured fibular.  On October 29, 2008 at approximately 3:30 PM and 4:45 PM Client #1 was observed sitting in a chair in with her feet on the floor. In an interview with the RN earlier the same day, she stated that the clients legs were to be elevated while sitting the control of the clients.	and a series of the series of		consistently adher	re to	
				Physician's Order	s (POSs).	
				TITE - White - Ann		•
1				The RN will on a	nonthly	•
1				basis review the P	OSs to	
l	Training documentation	to be elevated while sitting.		ensure compliance		-
			İ		12/01/08	
	AAAAIAAN NAMINUU UU II			W 331.6		•
	after the swelling was		ļ	Cross Reference V		ļ
		. 1		Cross Vertilefice A	V 192.	
1.	7. Cross refer to W36	6. The facility's nursing				
	administered in completers.	iance with the physician's			2/01/08	·
340 4	483.460(c)(5)(i) NURS	ING SERVICES	104.0-	W 331.7		ſ
Nursing other mappropri	Vursing services	include implementing with mandisciplinary team,	W 340	Cross reference W.	331.5.	
	ppropriate protection	merciscipinary team,	1		(2/01/98	1
			1			ı
	ealth and hygiene me					1
		1				: 1
T	his Standard &	t met as evidenced by:				
B	ased on observation, i	Titerview and reco-			}	.
	LITTLE AND INCHES AND INCHES	RING Services falled to	1			- 1
\$-2567(t	(2-99) Previous Virgions Obso	Svent ID: BOFJ11	]			ł

MAJY DIM	NT OF DEFICIENCES OF CORRECTION	IT AND HUMAN SERVICES  LE & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BULD		FORM APPRO OMB NO. 0938-( COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	09G218	9. WING		1	C
					1 444	14/200g
WHOUS	ITIC SERVICES, X		S	REET ADDRESS, CITY, STATE, ZIP CODE		TWZZJUG
(X4) ID				THE VAN HUNCH STREET MAN		
PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRINCEDED BY FULL SC INCOMPRESENTED	ID ID	WASHINGTON, DC 20012		
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	TION ULD BE	COMPLETION
W 340	Continued From pa			DEFICIENCY	OPRIATE	· DATE
	implement an effect to clients and elect	tive system to ensure training	W 340			
	for one of one client #1)	t in the investigation. (Client				
	The finding includes	e				
	Cross referee to W3	31.8. Client#1 was				
- 1	October 30 2008 av	ity on October 28, 2008 and	-	W 340	·	
•	written in the nursing	protocol. Additionally, the	•	Cross Reference W331.6.	-	
			1			
		realed that the clients legs hile there on October 29, training documentation		12/01/0	8	•
					}	<u></u>
8	ix day after the swel	ling was noticed.	}	•	İ	` .
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, AND HO	MENT OF DEFICIENCIES AM OF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NU	er/Clia JMBER;	A. BUILDIN		DN	(XI) DATE:	LETED	
MAME O	F PROVIDER OR SUPPLIER						C 14/2008		
	ISTIC SERVICES, X	•	1 1419 VAI	odress, city, : In Bliren 51 Gton, DC 2	STATE ZIP CODE		137	14/2008	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCE			· ·				
TAG	(EACH DEFICIENCY REQUILATORY OR LS	SC IDENTIFYING INFORMA	FULL ATION)	PREFIX TAG		RECTIVE ACTION I RECTIVE ACTION I RENCED TO THE A DEFICIENCY)		(205) COMPLETE DATE	
•	On October 27, 2006 Agency (SA) receive (UIR) via facsimile re According to the UIR 6:50 PM, the direct a #1's right leg was sw ankle. The direct car to the house manage the Registered Nurse The RN instructed the a Trained Medication	of at 3:36 PM, the Stand an unusual incider agarding Resident #73, 200 at a front her kneed that Resident from her kneed the front her (HM). The HM information on the same of the House manager, we have a front her agard.	ont report #1, 108 at sident e to her findings formed day, who was	1 000				Control of the open of the ope	
	administer PRN (as n The Primary Care Phy client on October 24, x-ray of the client's ri the client sustained a Due to the nature of the investigation was initial evaluate the GHMRPs health and safety to its	needed) medication financian (PCP) evaluation (PCP) evaluations. The PCP orderight log, which reveal right distal fibular fraction incident an on site atted on October 29, 25 supporter the control of t	for pain. lated the dared an aled that acture.					1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	The findings of the involved involved in the group observation at the group program; interviews with program staff, the Qual Professional (QMRP), the HM, and the review medical/clinical/administration.	vestigation was based tup home and the day fith group home staff, alified Mental Retards the Registered Nurse w of istrative records,	ly f, day					* * * * * * * * * * * * * * * * * * *	
E T E R	3514.2 RESIDENT RE Each record shall be ke signed by each individu This Statute is not met The GHMRP failed to e entries in the medical re Resident #1.	ept current, dated, ar ual who makes an en t as evidenced by:	ind ntry.	291		· ,		-	
_	ntutto The			<del></del>				- 1	
TORY D	RECTORS OR PROVIDERS	The same of the sa			Vice Preside	1			

if continuation sheet 2 of 3

AND PLAN	ENT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLI IDENTIFICATION NO	ERICLIA IMBER:	(XZ) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE	M APPROV		
		09G218		B. WING		-			
NAME OF	PROVIDER OR SUPPLIER						C		
WHOLI	STIC SERVICES, X		SINCETAD	DRESS, CITY,	STATE, ZIP CODE		14/2008		
			WASHING	19 VAN BUREN STREET, NW ASHINGTON, DC 20012					
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCE		<del></del>	T				
TAG		TEMENT OF DEFICIENCE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL (TION)	id Prefix Tag	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD RE	COMPLET		
I 291	Continued From pag	ge 1		1291	ATT CALL		-		
	On October 23, 2008 the direct staff notice Rasident #1's right leg was swollen from his knee to her ankle. The direct care staff reptihe findings to the house manager. The homanager informed the Registered Nurse (Richard Same day. The RN instructed the House manager, who was a Trained Medication Employee (TME) to administer pain medicatine resident. The Primary Care Physician (I evaluated the resident on October 24, 2008. Interview with the Registered Nurse on October 28, 2008, at 11:30 AM revealed that the physician of the resident on October 24, 2008. Review of the resident on October 24, 2008. Review of the resident on October 24, 2008. Review of the resident's record on the same revealed a consultation form which which documented the resident's diagnosis and treatment plan. Although the physician signs the form, the physician failed to date the form		her sported house (RN) on use cation to I (PCP) 18. ctober hysician 18. ne day		I 291 Cross reference WI W 153	114. <del>+</del> 12/01/08			
i 379 3	519,10 EMERGENCE	ES	rm.	379					
in in ar pli be	addition to the report ach GHMRP shall not sellin. Health Facilities the resident or ever terferes with a resident targement, well being aces the resident at rismade by talephone is lowed up by written nenty-four (24) hours of aces.	by the Department of a Division of any other authorization of any other way of a roll	of er ly living shall if be						
GH	is Statute is not met; sed on interview and i IMRP failed to ensure Administration						:		

	NT OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/BLIPPLE IDENTIFICATION NUI  09GZ18	r/Clia MBER:	(X2) MULTE A BUILDING B. WING	LE CONSTRUCTION	(XII) DATE	
AME OF	PROVIDER OR SUPPLIER		STREET ASSE			1	C 1 <b>4/2008</b>
VHQLIS	TIC SERVICES, X	1	OLKEE LYDD	RESS, CITY, 81	ATE ZIP CODE	11/	
	1 to BEILAICES, X	1	TATE VAN	BUREN ST	REET, NW		
(X4) ID	SI KENADY DYS			ON, DC 20	712	-	
PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY A		ID I	Ours and the		
TAG	REGULATORY OR LE	SC (DENTIFYING INFORMAT	TULL	PREFIX	PROVIDER'S PLAN OF CORRECTION SHO	TON	0.5
				TAG-		OPPIATE	COMPLETE
1379	Continued From pag		<del></del> -		DEFICIENCY)	OF TOTAL	DATE
-				379			<u> </u>
ı	origin are reported to	the facility's adminis	<del></del>	ł			1.
i							
ļ		R Chapter 35 Section		Í	•	i	_
ł	3919.10).		• }	- 1			
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	The findings include:		1	ļ			1, 2,
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- 1	Review of an unusua	l incident report date	,	1		!	
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				i	Cross reference W153.		
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